SENATE BILL NO. 127

INTRODUCED BY KEENAN

BY REQUEST OF THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT FACILITATING THE IMPLEMENTATION OF CERTAIN RECOMMENDATIONS OF THE MONTANA PUBLIC HEALTH CARE REDESIGN PROJECT REGARDING PROGRAMS OF HOME AND COMMUNITY-BASED SERVICES FUNDED WITH MEDICAID MONEY; REVISING THE STATUTES AUTHORIZING PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FUNDED WITH MEDICAID MONEY; AUTHORIZING THE LONG-TERM CARE PREADMISSION SCREENING ~~AND ANNUAL RESIDENT REVIEW~~ PROCESS; REMOVING AN INAPPROPRIATE APPLICATION OF MEDICAID STATE PLAN AUTHORITY TO THE PROGRAMS OF HOME AND COMMUNITY-BASED SERVICES AND A REQUIREMENT FOR REPORTING COSTS OF PROVIDING HOME AND COMMUNITY-BASED SERVICES TO PERSONS CURRENTLY LIVING IN ASSISTED LIVING FACILITIES; AMENDING SECTIONS 53-6-101, 53-6-401, AND 53-6-402, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 53-6-101, MCA, is amended to read:

"53-6-101. Montana medicaid program -- authorization of services. (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq.~~, as may be amended.~~ The department ~~of public health and human services~~ shall administer the Montana medicaid program.

(2) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services, including minimum mammography examination as defined in 33-22-132;

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;

(h) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant women;

(j) services that are provided by physician assistants-certified within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(k) health services provided under a physician's orders by a public health department; and

(l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2).

(3) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 10;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital services for persons under 21 years of age;

(l) services of professional counselors licensed under Title 37, chapter 23;

(m) hospice care, as defined in 42 U.S.C. 1396d(o);

(n) case management services as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted case management services for the mentally ill;

(o) services of psychologists licensed under Title 37, chapter 17;

(p) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201; and

(q) any additional medical service or aid allowable under or provided by the federal Social Security Act.

(4) Services for persons qualifying for medicaid under the medically needy category of assistance as described in 53-6-131 may be more limited in amount, scope, and duration than services provided to others qualifying for assistance under the Montana medicaid program. The department is not required to provide all of the services listed in subsections (2) and (3) to persons qualifying for medicaid under the medically needy category of assistance.

(5) In accordance with federal law or waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department ~~of public health and human services~~ may implement limited medicaid benefits, to be known as basic medicaid, for adult recipients who are eligible because they are receiving financial assistance, as defined in 53-4-201, as the specified caretaker relative of a dependent child under the FAIM project and for all adult recipients of medical assistance only who are covered under a group related to a program providing financial assistance, as defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in subsections (2)(a) through (2)(l) but may include those optional services listed in subsections (3)(a) through (3)(q) that the department in its discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated by the legislature, whether approval has been received as provided in 53-1-612, and whether the provision of a particular service is commonly covered by private health insurance plans. However, a recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage.

(6) The department may implement, as provided for in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(7) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(8) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost-effective.

(9) The amount, scope, and duration of services provided under this part must be determined by the

department in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended.

(10) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(11) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program.

~~(12) Community-based medicaid services, as provided for in part 4 of this chapter, must be provided in accordance with the provisions of this chapter and the rules adopted under this chapter.~~

~~(13) Medicaid payment for assisted living facilities may not be made unless the department certifies to the director of the governor's office of budget and program planning that payment to this type of provider would, in the aggregate, be a cost-effective alternative to services otherwise provided.~~"

Section 2. Section 53-6-401, MCA, is amended to read:

"53-6-401. Definitions. As used in this part, the following definitions apply:

~~(1) "Community-based medicaid services" means those long-term medical, habilitative, rehabilitative, and other services that are available to medicaid-eligible persons in a community setting or in a person's home as a substitute for medicaid services provided in long-term care facilities and that are allowed under the state medicaid plan in order to avoid institutionalization.~~

~~(1) "Annual resident review" means an annual review of all long-term care facility residents who have been previously determined to have mental retardation or a mental illness for the purpose of determining whether the resident continues to have a primary need for nursing care services in a long-term care facility and, if a primary need exists, whether the resident is receiving appropriate specialized mental retardation services or mental health services as needed.~~

~~(2)~~(1) "Department" means the department of public health and human services provided for in 2-15-2201.

~~(3)~~(2) "Home and community-based services" means, as provided for in section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, and regulations implementing that statute, long-term medical, habilitative, rehabilitative, and other services provided in personal residences or in community settings and funded by the department with medicaid money.

~~(4)~~(3) "Level-of-care determination" means an assessment of a person and the resulting determination establishing whether long-term care facility services to be provided to the person are appropriate to meet the

health care and related circumstances and needs of the person.

~~(3)~~(5)(4) "Long-term care ~~facilities~~ facility" means ~~facilities~~ a facility that ~~are~~ is certified by the department, as provided in 53-6-106, to provide skilled or intermediate nursing care services, including intermediate nursing care services for persons with developmental disabilities or, for the purposes of implementation of medicaid-funded programs of home and community-based services, that is recognized by the U.S. department of health and human services to be an institutional setting from which persons may be diverted through the receipt of home and community-based services.

~~(4) "Long-term care medicaid services" means community-based medicaid services and those medicaid services provided in long-term care facilities.~~

~~(5)~~(6)(5) "Long-term care preadmission screening ~~and resident review~~" means, ~~an evaluation that results in a determination as to~~ in accordance with section 1919 of Title XIX of the Social Security Act, 42 U.S.C. 1396r, a process conducted according to a specific set of criteria for determining whether a person ~~requires the services provided in long-term care facilities and whether community-based medicaid services would be an appropriate substitute for medicaid services that are available in long-term care facilities~~ with mental retardation or mental illness may be admitted to a long-term care facility.

~~(7)~~(6) "Persons with disabilities or persons who are elderly" means, for purposes of establishing home and community-based services, those categories of persons who are elderly and disabled as defined in accordance with section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n."

Section 3. Section 53-6-402, MCA, is amended to read:

"53-6-402. ~~Community-based~~ Medicaid-funded home and community-based services -- waivers -- funding limitations -- populations -- services -- providers -- long-term care ~~facilities~~ preadmission screening ~~and annual resident review~~ -- powers and duties of department -- rulemaking authority. (1) The department may ~~operate, for persons eligible for medicaid, a program of~~ obtain waivers of federal medicaid law in accordance with section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, and administer programs of home and community-based services ~~as an alternative to long-term care facility services in accordance with the provisions of Title XIX of the Social Security Act, as may be amended~~ funded with medicaid money for categories of persons with disabilities or persons who are elderly.

(2) The department may, subject to the terms and conditions of a federal waiver of law, administer programs of home and community-based services to serve persons with disabilities or persons who are elderly

who meet the level of care requirements for one of the categories of long-term care services that may be funded with medicaid money. Persons with disabilities include persons with physical disabilities, chronic mental illness, developmental disabilities, brain injury, or other characteristics and needs recognized as appropriate populations by the U.S. department of health and human services. Programs may serve combinations of populations and subsets of populations that are appropriate subjects for a particular program of services.

(3) The provision of services to a specific population through a home and community-based services program must be less costly in total medicaid funding than serving that population through the categories of long-term care facility services that the specific population would be eligible to receive otherwise.

(4) The department may initiate and operate a home and community-based services program to more efficiently apply available state general fund money, other available state and local public and private money, and federal money to the development and maintenance of medicaid-funded programs of health care and related services and to structure those programs for more efficient and effective delivery to specific populations.

(5) The department, in establishing programs of home and community-based services, shall administer the expenditures for each program within the available state spending authority that may be applied to that program. In establishing covered services for a home and community-based services program, the department shall establish those services in a manner to ensure that the resulting expenditures remain within the available funding for that program. To the extent permitted under federal law, the department may adopt financial participation requirements for enrollees in a home and community-based services program to foster appropriate utilization of services among enrollees and to maintain fiscal accountability of the program. The department may adopt financial participation requirements that may include but are not limited to copayments, payment of monthly or yearly enrollment fees, or deductibles. The financial participation requirements adopted by the department may vary among the various home and community-based services programs. The department, as necessary, may further limit enrollment in programs, reduce the per capita expenditures available to enrollees, and modify and reduce the types and amounts of services available through a home and community-based services program when the department determines that expenditures for a program are reasonably expected to exceed the available spending authority.

(6) The department may consider the following populations or subsets of populations for home and community-based services programs:

(a) persons with developmental disabilities who need, on an ongoing or frequent basis, habilitative and other specialized and supportive developmental disabilities services to meet their needs of daily living and to

maintain the persons in community-integrated residential and day or work situations;

(b) persons with developmental disabilities who are 18 years of age and older and who are in need of habilitative and other specialized and supportive developmental disabilities services necessary to maintain the persons in personal residential situations and in integrated work opportunities;

(c) persons 18 years of age and older with developmental disabilities and chronic mental illness who are in need of mental health services in addition to habilitative and other developmental disabilities services necessary to meet their needs of daily living, to treat the their mental illness, and to maintain the persons in community-integrated residential and day or work situations;

(d) children under 21 years of age ~~with chronic mental illness~~ who are SERIOUSLY EMOTIONALLY DISTURBED AND in need of mental health and other specialized and supportive services to treat their mental illness and to maintain the children with their families or in other community-integrated residential situations;

(e) persons 18 years of age and older with brain injuries who are in need, on an ongoing or frequent basis, of habilitative and other specialized and supportive services to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations;

(f) persons 18 years of age ~~or~~ AND older with physical disabilities who are in need, on an ongoing or frequent basis, of specialized health services and personal assistance and other supportive services necessary to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations;

(g) persons with human immunodeficiency virus (HIV) infection who are in need of specialized health services and intensive pharmaceutical therapeutic regimens for abatement and control of the HIV infection and related symptoms in order to maintain the persons in personal residential situations;

(h) persons with chronic mental illness who suffer from serious chemical dependency and who are in need of intensive mental health and chemical dependency services to maintain the persons in personal or other community-integrated residential situations; ~~or~~

(i) persons 65 years of age ~~or~~ AND older who are in need, on an ongoing or frequent basis, of health services, personal assistance, and other supportive services necessary to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations; OR

(J) PERSONS 18 YEARS OF AGE AND OLDER WITH CHRONIC MENTAL ILLNESS WHO ARE IN NEED, ON AN ONGOING OR FREQUENT BASIS, OF SPECIALIZED HEALTH SERVICES AND OTHER SUPPORTIVE SERVICES NECESSARY TO MEET THEIR NEEDS OF DAILY LIVING AND TO MAINTAIN THE PERSONS IN PERSONAL OR OTHER COMMUNITY-INTEGRATED RESIDENTIAL

SITUATIONS.

(7) For each authorized program of home and community-based services, the department shall set limits on overall expenditures and enrollment and limit expenditures as necessary to conform with the requirements of section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, and the conditions placed upon approval of a program authorized through a waiver of federal law by the U.S. department of health and human services.

(8) A home and community-based services program may include any of the following categories of services as determined by the department to be appropriate for the population or populations to be served and as approved by the U.S. department of health and human services:

(a) case management services;

(b) homemaker services;

(c) home health aide services;

(d) personal care services;

(e) adult day health services;

(f) habilitation services;

(g) respite care services; and

(h) other cost-effective services appropriate for maintaining the health and well-being of persons and to avoid institutionalization of persons.

(9) Subject to the approval of the U.S. department of health and human services, the department may establish appropriate programs of home and community-based services under this section in conjunction with programs that have limited pools of providers or with managed care arrangements, as implemented through 53-6-116 and as authorized under section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, or in conjunction with a health insurance flexibility and accountability demonstration initiative or other demonstration project as authorized under section 1115 of Title XI of the Social Security Act, 42 U.S.C. 1315.

~~(2)~~(10) (a) The department may conduct long-term care preadmission screenings ~~and annual resident reviews~~ in accordance with section 1919 of Title XIX of the Social Security Act, 42 U.S.C. 1396r.

(b) Long-term care preadmission screenings ~~and resident reviews~~ are required for all ~~medicaid-eligible~~ persons ~~entering~~ seeking admission to a long-term care ~~facilities and community-based services and for all persons who become eligible for medicaid after entering long-term care facilities, before payment for services in such settings are authorized under medicaid. Preadmission screenings and resident review of persons not~~

~~applying for medical assistance under this part must be on a voluntary basis, except as required under the Social Security Act~~ facility.

~~(c) Annual resident reviews are required for all persons with mental retardation or mental illness who are residents of long-term care facilities.~~

~~(d)~~(C) A person determined through a long-term care preadmission screening to have mental retardation or a mental illness may not reside in a long-term care facility unless the person meets the long-term care level-of-care determination applicable to the type of facility and is determined to have a primary need for the care provided through the facility.

~~(e)~~(D) The long-term care preadmission screenings ~~and annual resident reviews~~ must include a determination of whether the person needs specialized mental retardation or mental health treatment while residing in the facility.

~~(3) The department shall annually advise medical doctors and current residents of long-term care facilities of the program provided in subsection (1).~~

~~(4)~~(11) The department may adopt rules necessary to implement ~~a program of community-based medicaid services and to establish a system of~~ the long-term care preadmission ~~screenings and annual resident reviews as part of that program~~ ~~review~~ SCREENING process as required by section 1919 of Title XIX of the Social Security Act, 42 U.S.C. 1396r. The rules must provide criteria, procedures, schedules, delegations of responsibilities, and other requirements necessary to implement long-term care preadmission screenings ~~and annual resident reviews~~.

(12) The department shall adopt rules necessary for the implementation of each program of home and community-based services. The rules may include but are not limited to the following:

(a) the populations or subsets of populations, as provided in subsection (6), to be served in each program;

(b) limits on enrollment;

(c) limits on per capita expenditures;

(d) requirements and limitations for service costs and expenditures;

(e) eligibility categories criteria, requirements, and related measures;

(f) designation and description of the types and features of the particular services provided for under subsection (8);

(g) provider requirements and reimbursement;

(h) financial participation requirements for enrollees as provided in subsection (5);

(i) utilization measures;

(j) measures to ensure the appropriateness and quality of services to be delivered; and

(k) other appropriate provisions necessary to the administration of the program and the delivery of services in accordance with 42 U.S.C. 1396n and any conditions placed upon approval of a program by the U.S. department of health and human services."

NEW SECTION. **Section 4. Directions to code commissioner.** Wherever a reference to "community-based medicaid services" appears in legislation enacted by the 2005 legislature, the code commissioner is directed to change it to an appropriate reference to "home and community-based services".

NEW SECTION. **Section 5. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 6. Effective date.** [This act] is effective on passage and approval.

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